(13) (12)

Nos. 84-325, 84-356.

Supreme Court, U.S.
FILED
DEC 20 1984
ALEXANDER L. STEVAS
CLERK

In the
Supreme Court of the United States.

OCTOBER TERM, 1984.

METROPOLITAN LIFE INSURANCE COMPANY,
APPELLANT,
v.
COMMONWEALTH OF MASSACHUSETTS,
APPELLEE.

THE TRAVELERS INSURANCE COMPANY,
APPELLANT,
v.
COMMONWEALTH OF MASSACHUSETTS,
APPELLEE.

ON APPEAL FROM THE SUPREME JUDICIAL COURT FOR THE COMMONWEALTH OF MASSACHUSETTS.

Brief Amicus Curiae of the International Brotherhood of Electrical Workers Local 421 Health & Welfare Fund, the Sheet Metal Workers Local 297 Health and Welfare Fund, and the New Hampshire Plumbers Health and Welfare Fund, in Support of Appellants.

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December 20, 1984

BATEMAN & SLADE, INC. BOSTON, MASSACHUSETTS

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Question Presented.

Whether a state statute that requires insured employee benefit plans to provide specified minimum benefits for certain kinds of medical services is preempted by section 514(a) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1144(a).

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Interest of Amici Curiae.

*Amici** the International Brotherhood of Electrical Workers (IBEW) Local 421 Health and Welfare Fund, the Sheet Metal

* Pursuant to Supreme Court Rule 36.2, *amici* appear with the consent of all parties. Copies of the letters granting consent have been filed with this brief.

Workers Local 297 Health and Welfare Fund, and the New Hampshire Plumbers Health and Welfare Fund are located in the State of New Hampshire. They, along with five other funds who share a common administrator provide benefits to approximately 13,449 participants and beneficiaries in the construction industry in New Hampshire, Maine and Vermont (A. 1-36, 37). The funds are employee welfare benefit plans within the meaning of Section 3(1) of ERISA, 29 U.S.C. § 1002(1) (A. 1-38) (hereinafter referred to as "ERISA plans"). Additionally, they are "Taft-Hartley trusts" within the meaning of the Labor Management Relations Act, 29 U.S.C. § 186(c) (A. 1-39). Each of the plans is insured by policies purchased by them and member benefits are paid by the insurance companies in the first instance. This brief is being filed in support of appellants Metropolitan Life Insurance Company and the Travelers Insurance Company. *Amici* have a strong interest in seeing laws such as section 47B of Massachusetts General Laws chapter 175, which mandate the benefits to be provided by insured ERISA plans, invalidated. Such laws frustrate the ability of such plans to provide the benefits requested by their members, and increase both the cost of the plans themselves and of their administration. *Amici* believe these results were not intended by Congress when it enacted ERISA, and that ERISA's goals are frustrated by the enforcement of mandated benefit laws against either companies providing insurance policies to ERISA plans or the plans themselves.

Summary of Argument.

Employee benefit plans such as those represented by *amici* were in existence long before Congress enacted ERISA, and Congress clearly had them in mind when it was considering the

provisions of ERISA. One of the important aspects of such plans is the extent to which plan administrators and the members themselves determine the benefits to be afforded under the plan. Congress made a deliberate choice to leave this aspect of employee benefit plans governed by ERISA untouched, not only by the regulating provisions of ERISA, but also by state regulations. In interpreting, not only ERISA's preemption clause, but also the clause "saving" state insurance regulation, this Court should give full effect to Congress' intent.

The court below, and other courts which have upheld state laws purporting to be "insurance regulation" that mandate the benefits to be included in employee benefit plans, erroneously considered only the language of the law at issue in holding that, because it says it applies to insurance policies, it does not "directly" regulate the plans to which policies are issued. *Amici* believe the proper analysis is to consider the actual impact of such laws, which significantly interfere with the design and administration of such plans, as the actual experience of *amici* and similar plans illustrates. *Amici* believe that Congress, in enacting the insurance "saving" clause, had in mind "traditional" insurance regulation which would have only an incidental effect on plans insured by an insurance policy.

Laws which mandate the benefits to be included in a health insurance policy issued to an ERISA plan do nothing to advance the goals of "traditional" insurance regulation, which is made necessary because of the existence of the insurance industry. Rather, mandated benefit laws are simply means for achieving certain general health and welfare goals, which would be thought desirable regardless of the existence of insurance. On the other hand, mandated benefit laws do much to frustrate Congress' goals in enacting ERISA. Most importantly, they discourage the voluntary adoption of employee benefit plans

by making them more expensive and less suited to the needs of their members, and they threaten the solvency of plans already in existence.

Argument.

I. Based Upon the Experience of *Amici* with New Hampshire Laws Similar to Massachusetts General Laws c. 175, § 47B, Such Laws are Enacted, at Least in Part, for the Purpose of Mandating the Terms and Conditions of ERISA Plans, Regardless of the Extent to Which a Plan Is Insured. As Such, Mandated Benefit Laws Are Not "Insurance Regulation" Within the Meaning of ERISA § 514(b)(2)(A), Because They Have a Direct Effect on ERISA Plans, While Having Only an Indirect Impact on Insurance.

Amici funds were parties to a previous action challenging a New Hampshire mandated health benefit law similar to § 47B of Massachusetts General Laws c. 175, at issue in this litigation. The action was eventually reported as *Wadsworth* v. *Whaland*, 562 F.2d 70 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978). This was a challenge to N.H. RSA 415:18-a, 419:5-a, and 420:5-a. Like the Massachusetts statute, this law mandates the inclusion of mental health care benefits in group medical insurance policies, including policies issued to ERISA plans. The First Circuit held that the New Hampshire law was not preempted by § 514(a) of ERISA, 29 U.S.C. § 1144(a), to the extent that it applied to insurance policies issued to an ERISA plan. The court's holding turned on interpretations of § 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A), which saves state laws regulating insurance from preemption (the

"savings clause") and § 514(b)(2)(B) of ERISA, 29 U.S.C. § 1144(b)(2)(B), the so-called "deemer clause," which provides that a state may not deem an employee benefit plan to be an insurance company, insurer, or in the business of insurance for the purposes of its insurance laws. In the first instance, the First Circuit held that the New Hampshire mandated benefit law at issue "is . . . a state law regulating insurance," 562 F.2d at 77, for purposes of the savings clause, and secondly, that it only indirectly affected the ERISA plans involved, so that the "deemer clause," which "does not prohibit a state from indirectly affecting plans by regulating the contents of group insurance policies purchased by the plans," *id.* at 78, did not apply.

The opinion of the Massachusetts Supreme Judicial Court in this case reflects a similar analysis: "the statute as we consider it makes no attempt to regulate employee benefit plans directly." *Attorney General* v. *Travelers Insurance Co.*, 391 Mass. 730, 735 (1984). In both instances the conclusion was reached that mandated benefit laws only indirectly affect ERISA plans without any analysis of how the distinction between a "direct" and "indirect" effect should be determined; the assumption seems to be that only the language, and not the actual impact of a law should be considered. As will be discussed in greater detail, *infra*, *amici* believe mandated benefit laws are preempted, and not subject to the "savings clause," because, unlike "traditional"[1] insurance regulation, they directly affect and interfere with employee benefit plans, while having much less of an impact on the insurance companies which issue policies to the plans. Furthermore, in determining whether a state law "regulates insurance" within the meaning of the savings clause, and whether it falls within the prohibition of the deemer clause,

[1] Throughout this brief, when the phrase "traditional insurance regulation" is used, it refers to the same phrase as used and defined by appellant Metropolitan in its brief.

amici suggest that the only approach which would give full effect to Congress' intention is to look at the *actual* impact of the law, rather than its *purported* effect. This is the approach suggested by Justice Wilkins, who dissented below. As he pointed out, "General Laws c. 175, § 47B, is not a law 'which regulates insurance' within the meaning of ERISA § 514(b)(2)(A). As applied to employers, § 47B concerns health benefits that an employer must provide, . . . and as to employee benefits § 47B only incidentally regulates insurance." 391 Mass. 736.

Since the decision in *Wadsworth*, the State of New Hampshire has taken additional steps to try to regulate employee benefit plans covered by ERISA. In 1981 the State Legislature enacted Chapter 391 of the Laws of 1981, codified at N.H. RSA 415:18 VII(g), which required a 39-week extension of benefits to any beneficiary of a group health and accident plan who became ineligible as a result of the termination of the plan, for whatever reason. Unlike Massachusetts, which has disavowed any intention to enforce its law against self-insured plans, 391 Mass. at 730-731 n.2, the New Hampshire Legislature and Insurance Department applied the law "to all group health policies or contracts . . . and . . . all self-funded or self-insured employee health benefit plans." *Dawson* v. *Whaland*, 529 F.Supp. 626, 630 n.10 (D.N.H. 1982). This attempt was struck down by the District Court for the District of New Hampshire.

That court additionally held that, because the insurance policies issued to the funds involved in that case were, in all cases, "experience-rated," and in most cases "stop-loss" policies, *id.* at 628, the "Funds fall within the definition of 'self-funded or self-insured employee health benefit plans'." *Id.* at 630. *See also Wadsworth* v. *Whaland* at 75, citing *General Electric Co.* v. *Gilbert*, 429 U.S. 125, 129 n.3 (1976) (funds whose policies are experience-rated are, "for all practical purposes . . . self-insurer[s]"); *General Split Corp.* v. *Mitchell*,

523 F.Supp. 427 (E.D. Wis. 1981) (application of state insurance regulations to funds insured by stop-loss policies is preempted).

Since the decision in *Dawson* v. *Whaland* and the *dicta* in *Wadsworth* suggesting that funds such as *amici* could properly characterize themselves as "self-insured" and thus avoid state insurance regulations, the New Hampshire Insurance Department has tried once again. Presently, New Hampshire Insurance Rule 401.01(e)(3) purports to require all stop-loss or excess insurance policies issued "to any employer with a self-funded employee benefit plan" to comply with both the mandated mental health care benefit law, N.H. RSA 415:18-a, and the 39-week extension law, N.H. RSA 415:18, VII, IX, X and XI.[2] While this illustrates the persistent and blatant attempts by at least one state to regulate the terms and conditions

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[2] New Hampshire Insurance Rule 401.01(e)(3) provides in full:

> (3) Additional standards applicable to group excess or group stop-loss policies.
>
> a. No insurer may issue a policy generally described as a group excess or group stop-loss policy to any employer with a self-funded employee benefit plan which plan provides benefits for medical or hospital expenses but which does not provide benefits for nervous and mental conditions that either equal or exceed the required benefit standards imposed upon a group or blanket accident and health insurance policy by RSA 415:18-a.
>
> b. Any insurer providing what is generally described as group excess insurance or group stop-loss insurance under a policy issued to any employer with a self-funded employee benefit plan which plan provides hospital or surgical expense insurance or major medical expense insurance must provide to either the employer's employees or to the dependents of any employee of the employer or to both such employees and dependents whose insurance under the employer's employee benefit plan terminates for any reason a conversion privilege that is identical to or more favorable than the conversion privilege required under a conventional group accident and health insurance policy by the New Hampshire insurance code and specifically by RSA 415:18, VII, IX, X, and XI.

of ERISA-covered employee benefit plans, and the consequent need for this Court to intervene and clarify the scope of ERISA's preemption, *amici* do not wish to suggest that this Court's decision should turn on whether a plan is technically self-insured or not. Rather, *amici* urge the Court to focus on the impact that mandated benefit laws such as those in force in Massachusetts and New Hampshire have on an employee benefit plan, as opposed to the insurance company issuing a policy to the plan; the impact is the same whether the plan is fully self-insured, partially insured, or fully insured.

II. In Construing ERISA § 514(b)(2)(A), This Court Should Consider Congress' Purposes in Enacting ERISA Which Were, Through Minimizing the Regulation of ERISA Plans, to Encourage Their Voluntary Adoption. Plans Such as *Amici*'s, Whose Members Play a Significant Role in Determining the Content of the Plans, Illustrate the Type of Plans Congress Wished to Encourage.

The administrator of *amici's* plans, Mr. James Dawson, testified at length in the trial of this case (A. 1-29, 1-98). His experience in administering employee benefit plans dates back to 1953 (Tr. 1-30) when the first plan was established through the collective bargaining process. As he described, the union members have a great deal to say about the type of benefits to be included in their plan:

> I go to the union meetings, and we . . . suggest to them the various types of coverages that are available to us. Some coverages they turn thumbs down on absolutely. They are not interested at all . . . You can have a man stand up and say . . . 'I certainly feel we've got to provide

> dental coverage.' Another young fellow, particularly, will get up and say, 'Lookit, I think maternity benefits are an absolute must' . . . Somebody else will say, 'Lookit, I've got a child here that can't even get passing grades in school because she needs a pair of glasses . . . and I can't afford [them]' . . . [M]embers . . . vocalize very vehemently about what they personally feel is needed . . . After the discussions are all over, the union actually takes a vote, and the predominant view [as to which benefits to seek] prevails.

(A. 1-43). Mr. Dawson described the process at the subsequent collective bargaining agreement negotiations as follows:

> [W]e discuss with the employer what we want. We might tell them we want surgical benefits, hospitalization, life insurance, weekly income protection, vision, dental, . . . Obviously you don't get everything you ask for . . . [I]t's actually a tradeoff between what they want and what the employers are willing to give them . . . [A]fter hard negotiations they wind up with a minimal package and hope that the next time around they'll add a few more benefits.

(A. 1-40, 1-41). As noted, at least some of the plans administered by Mr. Dawson predate ERISA. Congress doubtless had such plans in mind when it enacted ERISA and omitted from its provisions any attempt to dictate the contents of ERISA plans.

Congress recognized, when it passed ERISA, the importance to the national economy of encouraging voluntary employee benefit plans. Similarly, Mr. Dawson testified to the importance of such plans to the individual workers:

> I would say that in the last few years [health benefits play] . . . one of the dominant roles [in the negotiations between employer and employees] . . . because health care costs have escalated so tremendously, far more than any other segment of our economy . . . Therefore, the members are aware of these extreme costs. It's my personal feeling that a person can't afford not to have insurance in this day and age . . . [M]ost of the members feel that way about it . . . I've seen negotiations where no other benefit was discussed other than health care or pensions.

(A. 1-41).

In furtherance of its recognition of the importance of employee benefit plans, and in order to encourage their voluntary adoption, Congress made a deliberate choice to impose upon them the least regulation necessary.

> [A]ll of the provisions in the Act have been analyzed on the basis of their projected costs in relation to the anticipated benefit to the employee participant . . . The [House] Committee [on Education and Labor] believes that the legislative approach of establishing minimum standards and safeguards for private pensions is not only consistent with the retention of the freedom of decision making vital to pension plans, but in furtherance of the growth and development of the private pension system . . . The Bill reported by the Committee represents an effort to strike an appropriate balance between the interests of employers and labor organizations in maintaining flexibility in the design and operation of their pension programs, and the need of the workers for a level of protection which will adequately protect their rights and just expectations.

H.R. Rep. No. 533, 93 Cong., 2d Sess., reprinted in 1974 US Code Cong. & Ad News 4639-40, 4647. As noted by the United States District Court for the Eastern District of Michigan in *Michigan United Food & Commercial Workers Union* v. *Baerwaldt*, 572 F.Supp. 943 (E.D. Mich. 1983), appeal docketed, No. 83-1570 (6th Cir. 8/16/83):

> this nurturant attitude towards private plans must be carefully considered in determining the preemption issue . . . By generally disallowing state regulations that might enhance protections for employees within any particular state, Congress was making a judgment that the greater national good called for both a minimum and maximum on the regulation of employee benefit plans.

Id. at 949-950.

The court in *Baerwaldt* held that, in furtherance of this Congressional purpose, a Michigan law mandating benefits for substance abuse treatment in insurance policies issued to, *inter alia*, ERISA plans, was preempted. In so holding, the court adopted an approach similar to that suggested by *amici*, and, rather than looking only at what the law *purported* to do (regulate insurance), considered also the actual *effect* of the law on ERISA-covered employee benefit plans.

> I do not think that [the "savings"] clause was aimed at preserving state statutes which more than tangentially affect employee benefit plans . . . I find that its purpose was to avoid unintended and wholesale preemption of important fields of state concern by making clear that statutes only incidentally affecting employee benefit plans, but not regulating their terms and conditions, were not to be ousted . . . I would confine the term 'regulates

> insurance' so as to exclude laws which do not so much monitor the insurance industry as its customers from the clause's protection.

Id. at 948, 951. *See also Metropolitan Life Ins. Co.* v. *Insurance Com'r*, 51 Md. App. 122 (1982), *rev'd, Ins. Com'r. of State* v. *Metropolitan Life Ins.*, 296 Md. 334 (1983). (Invalidating, as preempted by ERISA, Maryland law requiring benefits for psychotherapy services.)

III. The Impact of the New Hampshire Mandated Benefit Law on *Amici* and Other Employee Benefit Plans has been Direct and Significant. It Has Required Them to Remove Benefits Desired by the Members, Increased Costs and Employee Hostility, and Threatened the Solvency of Some Plans. By Having This Impact Mandated Benefit Laws Frustrate Congress' Goals in Enacting ERISA.

As the Maryland appellate court in *Metropolitan Life* and the Eastern District of Michigan in *Baerwaldt* recognized, mandated benefit statutes impact directly and adversely on employee benefit plans, as opposed to the insurance industry, and should not therefore be considered "insurance regulation" within Congress' intent. In his trial testimony, Mr. Dawson, the administrator of *amici* plans, described the magnitude of the impact:

> In the case of the Northern New England Carpenters, [they] . . . felt they could not afford to pay for the benefits required by that statute and still keep all the benefits they had in their own particular plan. The net result was that

> they increased their eligibility requirements . . . and they eliminated all vision and dental care . . . . Basically, it had the same impact on most of the other plans . . . [B]esides a cost, it had an antagonistic result . . . The members became antagonistic to me as well as the very fact that they had to have something they didn't want and to give up something they did want . . . [T]he Bricklayers Fund went to a position where they were technically fin ..-cially insolvent . . . [T]hey . . . asked the employers . . . to take . . . an additional contribution out of their pay envelope . . . and put that money into the fund to keep it solvent.

(A. 1-55, 1-60). As Mr. Dawson's testimony illustrates, the cost of additional mandated benefits is absorbed directly by the plans, with a minimal corresponding effect on the insurance companies which insure the plans, since they are able to simply pass on to the funds the additional costs in the form of premium increases. Thus, the effect of mandated benefit statutes such as Massachusetts' and New Hampshire's clearly frustrates Congress' intent to permit the plans themselves to make the decisions as to the scope and terms of coverage. As this Court noted in *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), "ERISA leaves this question [of the content of an employee benefit] largely to the private parties creating the plan . . . [T]he private parties, not the Government, control the level of benefits." *Id.* at 509.

In addition to the cost of the additional benefits themselves, Mr. Dawson testified regarding the administrative burdens and costs imposed upon employee benefit plans by mandated benefit laws with respect to plans covering employees in more than one state:

> [I]f John Smith is contributing 73 cents an hour and John Brown is contributing 73 cents an hour and one of them lives in Maine and one lives in New Hampshire, . . . they are both contributing to the same plan . . . yet one has a coverage that the other one doesn't . . . [E]ven worse than that, . . . because the man living in Maine didn't have to have the New Hampshire benefits, he could have greater benefits in another area to compensate for it, you would have actual chaos there . . . [I]t causes tremendous resentment and real hardship.
>
> . . .
>
> ERISA requires . . . a plan description to be delivered to every participant . . .[W]e would have to produce a plan document for each particular state and what benefits that particular state had . . . [T]he trustees . . . felt that the cost impact of . . . providing separate booklets for everybody . . . would be greater than actually providing the uniform benefits for everybody . . . [T]hey spent the extra money to provide the same benefits for everyone regardless of where they lived or worked.
>
> . . .
>
> [I]t goes to the very basics of creating these plans. Plans such as the Carpenters' were created in order that you might have uniform benefits for people who have to work in three different states . . . [I]f you're going to create havoc, in my opinion, by having different mandated benefits in all three states, you are going to increase tremendously the administrative costs.

(A. 1-62, 1-66). This, again, is a concern that was at the heart of Congress' purpose in enacting ERISA. In *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 103 S.Ct. 2890 (1983), this Court considered that concern at some length, and "Congress'

goal of ensuring that employers would not face 'conflicting or inconsistent state and local regulation of employee benefit plans." 103 S.Ct. at 2904. This Court concluded that Congress' concerns lay at the heart of the preemption clause. "By establishing benefit plan regulation 'as exclusively a federal concern' [cite omitted] . . . Congress minimized the need for interstate employers to administer their plans differently in each State in which they have employees." *Id.* at 2904. Just as this Court construed the ERISA provisions at issue in *Shaw* in light of Congress' purpose to minimize conflicting state regulations so should it construe the insurance "savings" clause.

IV. Section 514(b)(2)(A) of ERISA, the "Savings Clause", Should Not Be Held to Apply to Mandated Benefit Laws, Which, Although Nominally "Insurance Regulation," Impact Directly and Adversely on ERISA Plans, as Opposed to Their Insurers, Which Have No Necessary Relationship to the Insurance Industry, and Which Serve None of the Goals of Traditional Insurance Regulation.

The Court below distinguished *Shaw* on the ground that it did not address ERISA § 514(b)(2)(A), the "savings clause." If the savings clause were not at issue, however, *Shaw* and *Alessi* would be squarely applicable to the instant case; both invalidated State laws which had the effect of dictating the terms and conditions of employee benefit plans. However, as appellant Metropolitan points out in its brief, a State could easily avoid the results in those cases by couching its legislation in terms of "insurance regulation," assuming the reasoning of the Court below is correct. Under that rationale, New Jersey would be free to prohibit workers' compensation set off provi-

sions in insurance policies issued to employee benefit plans. Similarly, New York could forbid disparate treatment of pregnancy benefits in such insurance policies. This is essentially what Massachusetts has done. Had not Massachusetts included the language in § 47B relative to insurance policies, but simply required the inclusion of mental health benefits in employee benefit plans, *Alessi* and *Shaw* would control, and it is clear the statute would be preempted with respect to ERISA-covered plans. If preemption were not an issue, there would in fact be no need to include the reference to insurance policies. Regardless of whether the law is written to apply directly to the plan, or through an insurance policy, however, the impact on employee benefit plans would be the same.

This is not the case with legislation which appellants refer to as "traditional" insurance regulation. For example, *American Progressive Life and Health Insurance Company* v. *Corcoran*, 715 F.2d 784 (2d Cir. 1983) upheld regulations establishing maximum commission rates for insurance salesmen. As the Court noted, the impact of those regulations fell squarely upon "the internal business practices of the [insurance] Company," *id.* at 787, as opposed to the plans the company insured. In the absence of the insurance industry, there would be no purpose for such regulations; the same cannot be said of mandated benefit statutes.

In *Bell* v. *Employee Security Benefit Association*, 437 F.Supp. 382 (D. Kansas 1977) (which held that defendant plan was not an employee benefit plan within the meaning of ERISA, and thus not exempt from State insurance regulation), the Court listed what it believed are "the primary purposes of insurance regulation": "first, to avoid overreaching by insurers; second, to assure solidity and solvency of insurers; third, to assure that rating classifications and rates are reasonable and fair." *Id.* at 391. While these purposes are served by "traditional" insurance regulation, it can hardly be said that they are

served by mandated benefit laws. Rather, it is apparent that the primary purpose of such laws is to promote the health and welfare of the citizens of a state by encouraging the use of certain types of health care (or, in the case of an anti-set-off law such as that in issue in *Alessi*, by increasing the income available to an injured person). The only reason for couching such laws as "insurance regulation" is to limit their applicability (presumably for political reasons) to persons who have already demonstrated a need and a willingness to pay for them. It could be argued that such laws fall within the purpose of preventing "overreaching" by insurance companies in the typical insurer-insured relationship. Such an insured might not otherwise have the bargaining power to require the inclusion in his or her health insurance policy of certain benefits at a reasonable cost, or the sophistication to foresee a need for their inclusion. This analysis, however, does not apply to an employee benefit plan of the type represented by *amici*. As the *Bell* Court points out, "there is no threat of overreaching when the given plan is provided on a non-profit basis. Any unfairness by the employer . . . would probably result in labor problems." *Id.* at 391. Certainly employee groups such as those represented by *amici* enjoy much greater bargaining power vis-a-vis insurance companies than a single policyholder, or an unorganized group of employees (such as those involved in *Bell*). Finally, while a state may argue that its inability to require employee benefit plans to purchase certain benefits increases premium costs for other policyholders, that is a result already sanctioned by Congress when it exempted employee benefit plans from state insurance regulation.

This is because employee benefit plans such as those represented by *amici* can at any time choose to become self-insured, which appellee concedes would free them of the impact of mandated benefit laws. That Congress could not have intended such an absurd result seems evident. On the one hand,

forcing employee benefits plans to become self-insured does nothing to further the goals of state insurance regulations. If anything, it would tend to increase insurance premiums in general, by drastically reducing the number of persons among whom a particular risk is spread. On the other hand, it would do much to frustrate Congress' intent to foster the growth and solvency of employee benefit plans. As Mr. Dawson testified, there is a very real risk that some plans would be unable to continue in existence if they were forced to become uninsured.

> Many of them are small plans that cannot afford to go uninsured . . . It's a Catch 22 situation. They can't afford the benefits, and they can't afford to avoid them by going uninsured . . . If they try to go uninsured, I think many of them will collapse.

(A. 1-66, 1-67, 1-68). In addition to the financial protection that insurance provides, Mr. Dawson spoke of other benefits afforded by purchasing insurance policies, which would be eliminated if the plans were forced to become self-insurers.

> The advantages of an insured plan . . . are the great stability and the experience and the knowledge and the know-how that any insurance company brings to the plan . . . As a third-party payer they are not subject to the political pressures that would be evident if, for instance, my office was personally paying the claims . . . [U]nion members, trustees, and so forth, could . . . put pressure on me and my employees to pay claims that normally should [not] [*sic*] have been paid.

(A. 1-49). That Congress recognized these benefits and contemplated the purchase of insurance is evident, not only in Section 3(1) of ERISA, 29 U.S.C. § 1002(1) which includes insured plans within the definition of plans covered by ERISA, but also in the recently-enacted Multiple Employer Trust (METS) amendments,[3] 29 U.S.C. § 1144(6)(A), which subject non-collectively-bargained uninsured employee benefit plans to more extensive state regulation than insured plans.

Conclusion.

In conclusion, *amici* respectfully urge this Court to hold that state laws which have the effect of mandating the benefits to be included in an employee welfare plan are preempted by Section 514(a) of ERISA, whether they are directed to insurance policies insuring such plans, or phrased more broadly. *Amici* urge this Court to narrowly construe Section 514(b)(2)(A) the "savings clause," to include only "traditional" state insur-

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[3] Enacted in 1983, § 1144(6)(A) of ERISA provides, in part:

> Notwithstanding any other provision of this section —
>
> (i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured . . . any law of any State which regulates insurance may apply to such arrangement to the extent that such laws provides
>
> (I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions . . . and
>
> (II) provisions to enforce such standards, and
>
> (ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, . . . any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter . . .

ance regulation, that is, regulation which has a direct impact only on the insurance industry and not, as here, customers who happen to be ERISA plans. Since mandated benefit laws such as § 47B and N.H. RSA 415:18-a, 419:5-a, and 420:5-a do not fall within that category and instead have a direct, adverse effect on the plans maintained by *amici* and similar plans, they should be struck down. The judgment of the Supreme Judicial Court of Massachusetts in this case should be reversed.

Respectfully submitted,

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December 20, 1984